Miami Valley Council Boy Scouts of America

PERSONAL HEALTH AND MEDICAL RECORD
CLASS 1- FOR CUB SCOUT DAY CAMP ONLY!

CLASS I- (Update annually for all participants). Activity: Day Camp, overnight hike, or other programs not exceeding 72 hours, with level of activity similar to that of home or school. Medical care is readily available. Current personal health and medical summary (history) is attested by parents to be accurate. This form is filled out by all participants and is on file for easy reference.

IDENTIFICATION

To be filled out by parent, guardian or adult participant. Please print in ink.

Name________________________________ **Date of Birth**____/____/____ **Age**____ **Sex**_____

Name of Parent or Guardian____________________________ **Home Phone (___)**____________

Business Phone (____)____________ **Home Address** ________________________ **City**___________

If the above named person is not available in case of an emergency, please provide names and phone numbers of someone able to pick up your child if the need arises.

Name______________________ Relationship______________ Phone/Cell/Pager (___)__________

Name______________________ Relationship______________ Phone/Cell/Pager (___)__________

MEDICAL INFORMATION

Name of Personal Physician ________________________________ Phone (___)____________

Personal health/accident carrier ________________________________ Policy______________

List any medication to be taken at Camp: ________________________________

Allergies: Check if they apply: Food____ Medicines____ Insects ____ Plants ____ Explain: ____________

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Check all items that apply past or present, to your health history. Explain any **YES** answers.

General Information:	Yes	No		Yes	No		Yes	No
Asthma	__	__	Diabetes	__	__	High Blood Pressure	__	__
Cancer/Leukemia	__	__	Heart Trouble	__	__	Kidney Disease	__	__
Convulsions/Seizures	__	__	Hemophilia	__	__	Other________	__	__

Explain: ____

List any physical or behavioral conditions that may effect or limit full participation in swimming, backpacking, hiking long distances, playing strenuous games or activities: ________________________________

List equipment needed such as wheelchairs, braces, glasses, contact lenses, etc: ________________________

Immunizations: (Give date of last inoculation)

Tetanus _______________	Measles_______________	Polio_______________
Diphtheria_______________	Mumps _______________	Other_______________
Pertussis_______________	Rubella_______________	Other_______________

I give my permission for full participation in the BSA program, subject to limitations noted herein.

In case of emergency, I understand every effort will be made to contact me (if an adult, my spouse or next of kin). In the event I cannot be reached, I hereby give my permission to the physician selected by the adult leader in charge to secure treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child (or for me, if an adult).

Date__________ Signature of Parent/guardian/or adult______________________________

Some hospitals require the parent/guardian signature to be notarized. Check with your local council.

Note: Some states require an annual pre-camp medical evaluation. Your BSA Local Council Service Center can advise you about the requirements for your state.

Name ______ LAST ______ FIRST ______ Pack: ______ District: ______